MDR Tracking Number: M5-04-2013-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The disputed dates of service 2-10-03, 2-17-03, and 2-19-03 are untimely and ineligible for review per TWCC Rule 133.308 (e)(1) which states that a request for medical dispute resolution shall be considered timely if it is received by the Commission no later than one year after the dates of service in dispute. This dispute was received on 2-20-04.

The IRO reviewed therapeutic exercises, myofascial release, manual electrical stimulation, ultrasound, office visits, and therapeutic activities from 7-30-03 to 8-6-03.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division. On 6-10-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

Per telephone conversation on 11-4-04, the requestor stated that all other fee issues had been paid by the carrier; therefore, no review of the fee issues.

The above Decision is hereby issued this 4th day of November 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

May 21, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-2013-01
TWCC #:
Injured Employee:
Requestor:
Respondent:
------ Case #:

------ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ------ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ------ for independent review in accordance with this Rule.

------ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ------ external review panel who is familiar with the with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ------ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ------ for independent review. In addition, the ------ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 46 year-old female who sustained a work related injury on ------. The patient reported that while at work she began to experience pain in the left elbow and arm. An IME dated 3/19/99 indicated that this patient's diagnoses included probable mild to moderately severe left radial tunnel syndrome and mild left lateral humeral epicondylitis. Treatment for this patient's condition has included diagnostic/therapeutic blocks of the radial tunnel and medications. An EMG performed on 4/26/00 indicated carpal tunnel syndrome on the left, cubital tunnel syndrome on the left, radial tunnel syndrome on the left, and persistent C-7 radiculopathy on the left. The patient underwent a carpal tunnel release, radial tunnel decompression and lateral humeral epicondylectomy on 6/1/00. Postoperatively the patient was treated with a physical therapy program. Following surgery the patient developed triggering in her left thumb with frank popping and clicking. This was treated with a steroid injection into the left thumb and subsequently underwent an excision of ganglion cyst of left thumb, release of A1 pulley, and flexor tenosynovectomy left thumb on 5/15/03. Postoperatively the patient was treated with further physical therapy.

Requested Services

Therapeutic exercises, myofascial release, electric stimulation (manual), ultrasound, ov/out pt visit E&M established, and one on one therapeutic activities from 7/30/03 through 8/6/03.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. SOAP notes 2/10/03 – 8/6/03
2. Lankford Hand Surgery note (IME) 3/16/99
3. Progress notes 4/13/99 – 4/25/01

Documents Submitted by Respondent:

1. No Documents Submitted

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is upheld.

Rationale/Basis for Decision

The ------ chiropractor reviewer noted that this case concerns a 46 year-old female who sustained a work related injury to his left elbow and arm on ------. The ------ chiropractor reviewer indicated that the injury sustained by this patient had probable cervical spine involvement. The ------ chiropractor reviewer noted that the patient had several complaints of left neck pain with the left arm, wrist and hand pain. However, the ------ chiropractor reviewer indicated that the documentation provided failed to demonstrate that any form of cervical spine treatment was rendered. The ------ chiropractor reviewer explained that there is no therapeutic benefit from the chiropractic care that was provided. The ------ chiropractor reviewer also explained that the treatment this patient was not curative and did not relieve this patient's pain. The ------ chiropractor reviewer further explained that there is no objective or subjective evidence that the treatment this patient received was medically necessary. Therefore, the ------ chiropractor consultant concluded that the therapeutic exercises, myofascial release, electric stimulation (manual), ultrasound, ov/out pt visit E&M established, and one on one therapeutic activities from 7/30/03 through 8/6/03 were not medically necessary to treat this patient's condition.

Sincerely,
